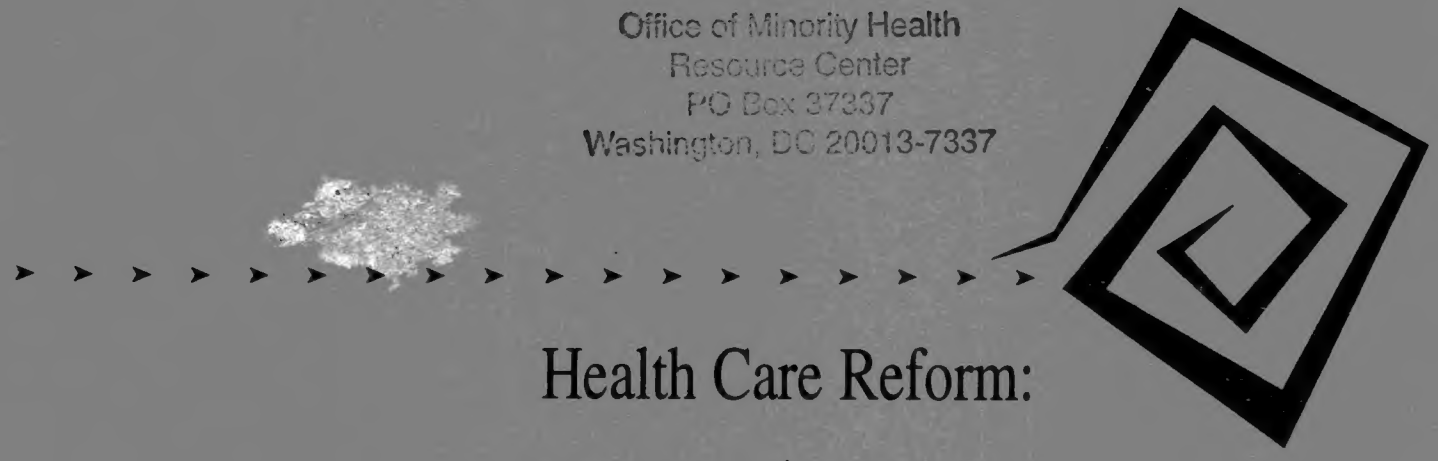

Health Care Reform: Assuring Access for Vulnerable Populations

A Symposium
March 23, 1994
Capital Hilton
Washington, D.C.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Primary Health Care

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Introduction

Not too long ago, the **Baltimore Sun** *reported on Roman McElvan from Bel Glade, Florida. Roman is a thin wisp of a man with memories of harvest but nothing to show for his labor—no land, no savings, no pension, not even Social Security—and no health insurance. 'They say I didn't work enough, despite all those years stooping to the Earth, all that time planting beans from dusk till dawn, chopping cotton in summer sun, and plucking tomatoes from pesticide-dusted vines.' He says this softly while glancing down at his rough, willing hands and toward his legs that were amputated a few years ago. Roman is why we are here today."*

– Opening remarks of the Symposium presented by:
Marilyn H. Gaston, M.D.
Assistant Surgeon General and Director, Bureau of Primary Health Care

Caring for vulnerable populations continues to be one of the Nation's most pressing health care problems. There are more than 43 million persons in the United States who are classified as medically underserved and are faced with significant barriers in accessing preventive and primary health care. The most vulnerable members of our society are those whose disadvantaged socioeconomic profile (e.g., income below the poverty level, ill-housed, minority, or non-English speaking) coexists with poor health status. A lack of access to health care often forces these individuals to seek care at later stages of disease, thus resulting in increased suffering and treatment costs.

Vulnerable populations include the following individuals:

- **Homeless persons.** There are an estimated 2 to 3 million people in the United States without permanent homes. Homeless people have a higher prevalence of many chronic and acute conditions than in the housed population.
- **Migrant farmworkers and their families.** This population includes about 4 million people whose travels through rural America make their access to care particularly problematic.
- **Persons with HIV and other serious infectious diseases such as multiple drug resistant tuberculosis.** Although they can be found throughout the Nation, persons with these conditions are disproportionately present in underserved communities.
- **Undocumented persons.** This group includes from 3 to 10 million people, and many have only tenuous connections with the U.S. health care system.
- **Persons with serious physical, developmental, and mental illness requiring special care.** Although they, too, are found throughout the Nation, medically underserved communities have a high incidence of conditions such as low infant birthweight that are associated with some lifelong disabilities such as retardation, cerebral palsy, and developmental disabilities.

To examine how vulnerable populations may access care under a reformed health care system, the Bureau of Primary Health Care (BPHC) and the National Association of Community Health Centers (NACHC) cosponsored a 1-day invitational symposium on March 23, 1994, in Washington, D.C. In developing the agenda of this meeting, the symposium Planning Committee was driven by a sense of advocacy for a group that needs a voice among the many competing voices that are shaping the Nation's future health care system.

Charged with the responsibility for increasing access to primary health care and improving the health status of underserved populations, the BPHC serves more than 7.4 million people through its programs. The BPHC is part of the Health Resources and Services Administration (HRSA), one of eight agencies of the Public Health Service in the U.S. Department of Health and Human Services. The BPHC provides leadership in promoting access to primary health care for medically underserved populations, including those with special needs such as the homeless and people with or at risk for HIV infection.

Programs such as Community and Migrant Health Centers, Health Care for the Homeless, and the Public Housing Primary Care Program build a primary care infrastructure by establishing systems of health care coordinated with social and support services. They provide comprehensive family-oriented primary health services in medically underserved communities that have high poverty rates, disadvantaged populations with health problems, and an insufficient supply of health professionals to serve these individuals. Patients are billed on a sliding-fee scale based on their ability to pay, so that a lack of income or health insurance is not a barrier to care.

The NACHC is a nonprofit membership organization that provides education, training, technical assistance, and advocacy for federally qualified health centers and medically underserved communities. The organization's mission is to promote high quality, comprehensive health care that is accessible, culturally and linguistically competent, and community directed for all medically underserved populations. The NACHC works in concert with chartered State and Regional Primary Care Associations to achieve program priorities.

To address the implications of health care reform among vulnerable populations, symposium planners called forth more than 30 experts in the field: Federal and State officials, congressional staff persons, the representatives of advocacy organizations, community health care providers, consumers, and spokespersons from health insurance and managed care organizations. All of these individuals contributed to the exploration of the topic through panel discussions, policy papers, speeches, and open forum discussions. An audience of approximately 200 professionals and policymakers attended the Symposium. Through the interaction of this group, the barriers to health care delivery for vulnerable populations were examined, and potential solutions were identified.

"In thinking creatively, we can develop new approaches to go beyond the four walls of our offices and meeting rooms and into the populations, neighborhoods, and the labor camps to reach people and work with them in a way that is meaningful."

This summary presents the crosscutting themes that emerged from the detailed, dynamic, and heartfelt discussions of the Symposium. It includes recommendations to ensure that the health care needs of the Nation's most underserved and vulnerable populations are met. The themes that follow should be considered by all groups engaged in providing health care to these populations, including individuals and organizations at the community level as well as State and Federal Government agencies.

Summary of Symposium Themes

1. **There is much debate on health care reform both in Washington and in State Capitals, particularly those states applying for Section 1115 HCFA waivers. For the most part, however, the discussion is about medical insurance reform and not health care reform.**

   - Medical insurance reform is critical, and decreasing the financial barriers is one of the first steps in improving access to care for vulnerable populations.
   - Insurance coverage in itself will not automatically make health care available and accessible to all Americans. The system cannot be considered "reformed" until every single child, family, and individual can truly access health services without any barriers to care.
   - The ultimate goal of health care reform must be to improve the health status not only of individuals but of communities as well.

2. **Universal coverage means coverage for all population groups.**

   - Denial of coverage to any group of individuals could have serious public health implications for the rest of the Nation.
   - Eligibility requirements must be flexible to accommodate persons who may not have complete identification such as the homeless.
   - Civil privacy must be protected in the health care system. Any type of health identification card cannot be used as a de facto national identification card.

3. **Vulnerable populations must be provided with a form of health coverage that is secure and portable.**

   - For most Americans, "secure and portable" translates into maintaining insurance even if they are laid off from their job or they have a preexisting condition. Insurance coverage for vulnerable populations such as the homeless must be flexible to meet their unique needs.
   - Although employer-based coverage would work for most people, it presents problems for covering those who are permanently unemployed or whose employment status changes frequently, especially migrant farmworkers.
   - Health care reform proposals that are based on a geographic area will not meet the needs of mobile population groups, especially if coverage for "out of the area" includes only urgent or emergency situations.

4. **Even in a system of universal coverage, traditional essential community providers will still be needed to provide care to vulnerable populations.**

   - Traditional providers of care to vulnerable population groups have made significant contributions to the current delivery system and have valuable insight into the needs of the people and their communities.
   - Traditional providers are access points to the delivery system in areas where vulnerable populations live.
   - A reformed delivery system must protect traditional providers to preserve existing provider relationships.
   - Community-based providers will be needed to serve as advocates for their patients who are covered by private insurance.

5. **Vulnerable populations must have a medical "home" that responds to their unique needs and is geographically and physically accessible as well as culturally and linguistically competent.**

- This medical home must provide comprehensive preventive and primary care services and be available during the hours that such individuals can seek care.
- It must provide services to enable individuals to access care, including transportation, outreach, case management, and language translation.
- This medical home also must be linked to specialty, tertiary, home, and residential care. It must provide liaison to health services such as substance abuse treatment programs and social services such as food, housing, and job programs.
- Health care providers in these facilities should represent the populations they serve and be culturally sensitive to their clients' needs.
- For vulnerable populations, it is particularly important that health care providers are sensitive to their unique life and environmental circumstances and develop appropriate treatment protocols.

6. **Enabling services are essential to removing nonfinancial barriers to care.**
   - Enabling services seek the most efficient way to address barriers, including language, culture, distance, and a lack of transportation.
   - Enabling services include outreach, transportation, translation, cultural competency, case management, and linkages to other health and social services. Enabling services have been shown not only to reduce barriers to care for the members of this group but also to improve health outcomes.
   - The challenge in a reformed system will be to reimburse providers for the provision of enabling services because these services are typically not covered in any basic benefit package.
7. **Although a single-tiered health care system is desirable, the capacity of essential community providers must be expanded as part of that system.**
   - Capacity should be maintained through continued investment in community-based facilities and providers.
   - The financing system must ensure that community-based providers remain viable by reimbursing them for enabling services.
   - Community-based providers must receive compensation for the care of individuals who, for whatever reason, are not covered by insurance.
8. **Because most reform measures would rely on private insurance, community providers and private insurers must work together to effectively serve vulnerable populations.**
   - There was recognition by the private insurance and managed care industry that access to health insurance does not automatically translate into accessing health care services. They also acknowledged that as an industry they need to do more to provide outreach and translation services.
   - There was also an acknowledgement by the industry that health care providers need community acceptance. Therefore, they expressed their willingness to work with community-based providers.
   - In addition, both the private insurance and managed care industry expressed an interest in beginning dialogue with traditional community-based providers on data collection, quality assurance, and risk adjustment.
9. **Although the managed care industry has expressed an interest in working to serve vulnerable populations better, protections for vulnerable populations must still be built into these plans.**
   - Enrollment processes must be designed so that individuals are actually able to enroll and receive care. Materials explaining benefits and options must be available in languages that are appropriate. Opportunities to enroll must be available at times and places where individuals are able to present themselves.
   - Benefit packages must include services that vulnerable populations need such as mental health and substance abuse services. Many individuals with special circumstances often require benefits that may not be considered essential for others.

- Copayments cannot present barriers to accessing appropriate services. Even modest cost sharing will prevent many people from seeking proper care.
- Consumers must have the right to change health care plans and be made aware of this right.
- Mechanisms must be included that allow consumers to make complaints and that allow an investigation of noncompliant plans.

10. **Despite an agreement on the overall goals of a reformed system, the managed care industry and community providers still have misunderstandings about each other that present obstacles to serving vulnerable populations.**

    - The managed care industry believes it can offer quality care to vulnerable populations because of its commitment to access, an emphasis on wellness and screening, and a focus on medical management of high-risk patient populations.
    - Providers and advocates for vulnerable populations, however, believe that private-sector managed care organizations do not have experience to care for their patients. There are examples of enrollment procedures causing confusion among patients who can no longer see their community-based provider.
    - In addition, although managed care organizations recognize the important contributions that community-based providers have made to the health care delivery system, they are firmly against any legislation that would mandate contracting to essential community providers.

Symposium Report

SYMPOSIUM COMMENCEMENT

The Symposium began with welcoming remarks from Assistant Surgeon General Marilyn H. Gaston, M.D. Dr. Gaston is encouraged with the opportunity that health care reform offers to reach millions of underserved Americans to improve their health status. She urged participants to generate solutions to ensure that no group falls through the safety net of health care reform.

Robert O. Valdez, Ph.D., Deputy Assistant Secretary for Interagency Policy, Public Health Service, Health Care Financing Administration (HCFA), Office of the Assistant Secretary for Health, also provided opening remarks. Dr. Valdez indicated that additional research is needed on the barriers to providing health care to vulnerable populations and on the organization and delivery of services to them. Even if health care reform results in the necessary financial resources to provide health care to vulnerable populations, there are other obstacles to meeting their needs such as language and cultural barriers.

Tom Van Coverden, Executive Director, NACHC, envisioned that the Symposium would result in creative methods of improving the health care received by vulnerable populations in their communities in an increasingly competitive and rapidly changing health care marketplace. He noted that some State health care reform plans had failed to include certain vulnerable populations or had made no special provisions for their enrollment and/or specialized services, despite their high degree of vulnerability.

Mr. Van Coverden indicated that because Section 1115 HCFA waivers have been provided to an increasing number of states to experiment with health care reform, many safety-net providers of health care for medically underserved individuals such as federally qualified health centers are finding that their funding is significantly diminished. Their patients are often enrolled in mandatory managed care plans without a full understanding that they have switched providers. This weakening of the community-based safety net of health providers is occurring without any assurances that managed care organizations will adequately reach and appropriately serve vulnerable populations.

Mr. Van Coverden commended the Administration for helping make reform of the health care system a national priority and listed several key questions his organization would like to see addressed by health care reform, whether national or State-based:

- Will there be universal coverage?
- Will there be guaranteed funding set aside to develop and foster community-based preventive and primary care in medically underserved areas and for medically underserved populations?
- Will there be a defined role for essential community providers?
- What will ensure that an infrastructure is maintained for programs that focus on outreach, preventive health care, and early intervention for vulnerable populations?

In seeking answers to these key questions, it is important for policymakers to examine cost-effective, quality preventive programs such as federally qualified health centers and to find ways to strengthen and expand them. Reliance on marketplace reforms alone may cause weakening or elimination of a much-needed preventive health care infrastructure, resulting in increases in health problems among the medically underserved and, ultimately, higher health care costs.

POLICY PAPER: VULNERABLE POPULATIONS AND HEALTH CARE REFORM

To provide background and context for the days discussions, Ann Zuvekas D.P.A., Senior Research Staff Scientist, Center for Health Policy Research, The George Washington University, presented a paper entitled "Vulnerable Populations and Health Care Reform." Dr. Zuvekas has more than 20 years of experience in the health care services field, with an emphasis on serving the needs of vulnerable populations.

Defining Vulnerable Populations and Their Needs

Although many individuals and groups could be considered vulnerable for a variety of reasons, the most vulnerable are those whose serious health conditions are exacerbated by poor socioeconomic conditions. When attempting to meet the needs of these individuals, policymakers must be aware that such populations are usually affected with multiple conditions that require more rather than less health care. These conditions can include asthma, hypertension, diabetes, tuberculosis, cancer, chronic mental illness, substance abuse, injuries from violent acts, and unintentional injury. Conditions that may not have a severe impact on the life of someone with access to appropriate medical care can become very serious for others. Without appropriate care, for example, chronic lower back pain in an agricultural worker may progress to the stage that he or she cannot perform field labor and support his or her family.

A Medical Home for Vulnerable Populations

Vulnerable populations must be provided with a medical "home" that takes responsibility for responding to their unique needs. This health care home must be geographically and physically accessible. It must provide comprehensive primary care services and be open during the hours in which people are able to seek care. The health care providers who staff this home must be culturally and linguistically competent. They must have enough experience to know not to provide bedrest for a homeless person without a bed or to prescribe medicine to be taken with meals three times a day for a family without a regular food source.

The facility must provide services to enable individuals to access care, including transportation, outreach, case management, and language translation. This medical home also must be linked to specialty, tertiary, home, and residential care services. It must provide liaison to health services such as substance abuse treatment programs and social services such as food, housing, and job programs. In addition, the system must be "mobile" to reach vulnerable populations wherever they are. For example, it must have the means to go to the fields to serve migrant workers and be able to follow this mobile group as they travel.

"Health care services have to be available during the hours people seek care. When I was a migrant health director, we knew that we would have people with symptoms of lower back strain, which was not life-threatening, on a sunny day when they were at work in the fields. But if we were trying to keep our hypertensives under control, we either had to provide service at night or, as we ended up doing, putting beepers on all the nurses and doctors and providing beefed-up care when it rained because people could not come out of the fields otherwise for asymptomatic conditions."

Meeting the Needs of Vulnerable Populations

Most of the major national health reform proposals would create a health care system that still relies on private insurance and private providers—a system that traditionally has not met the needs of vulnerable populations. Although universal private insurance coverage would remove a financial barrier to care, there are still many unanswered questions on how private insurance can best meet the unique needs of vulnerable populations. These following issues must be addressed.

- **Eligibility and enrollment mechanisms.** Many proposals indicate that all individuals are eligible, other than undocumented persons. However, just being eligible does not ensure that they will receive care. Mechanisms must be provided to ensure that individuals are able to enroll with an appropriate health care provider and can access needed services.
- **Security and portability.** Individuals must be able to take their insurance with them if they change employers. This issue is particularly important to

migrant farm workers who may work for many different employers each year in many different states. Such persons must be able to access health care wherever they are.

- **Benefit structure.** Many vulnerable population groups often have unique needs for benefits that may not be covered by many private insurance plans. For example, postacute care coverage must be provided for the homeless who have no where to go for their recuperation.

- **Affordability.** Although insurance converge will remove financial barriers for most people, even small copayments can present barriers for many people. Many individuals would be prevented from receiving care if even modest cost-sharing was required.

- **Incentives to serve vulnerable populations.** Although it is important to encourage responsible plans to serve vulnerable populations, without the appropriate incentives to provide quality care, these providers may try to accept premiums without providing services. The potential for underservice may also exist if there is a risk adjustment for high-risk individuals. In this case, vulnerable populations may be signed up yet never linked into the system to receive care. However, the care provider may still make a large profit for having them, at least on paper, in their system.

- **Accountability.** The less empowered or the voiceless members of a community must have a mechanism to express their concerns.

"Vulnerable populations must have a medical home that responds to their unique needs. The professionals who staff this home must know not to provide bedrest for a homeless person without a bed or to prescribe medicine to be taken with meals three times a day for a family without a regular food source."

The existence of universal insurance does not itself equal universal access to appropriate care. To be effective, universal coverage will have to be combined with a capacity to deliver care in communities and with services that enable vulnerable populations to use insurance coverage.

Managed care providers must make the necessary investment to bring physicians, additional personnel, and other health care resources into communities. Additionally, managed care providers must invest in community-based providers and networks, whether this is related to information systems or establishing networks to link hospitals and programs that provide health care for the homeless and migrant workers.

"A patient told me 'I've been given this card to go for health care, but no one there speaks my language.' This woman had access in a sense, but the program had failed a major litmus test of a good fit between patient and provider."

Enabling services such as outreach, transportation, language translation, case management, and linkages to other health and social services will still be needed to address attitudinal, geographic, and cultural barriers. Although they are vital to vulnerable populations, enabling services are not well-handled through an insurance mechanism because they could result in exorbitant expenses if made reimbursable and used by all populations. However, methods of making them available to the vulnerable, who vitally need them, must be incorporated into health care reform. These services have been shown not only to reduce barriers to care for the members of this group but also to improve health outcomes. This must be the goal of any health care system.

A CONSUMER'S PERSPECTIVE: A REPORT FROM A REPRESENTATIVE OF SEASONAL FARM WORKERS

Ms. Hazel Filoxsian, a seasonal farm worker, and Director, Migrant and Immigrant Assistance Center, Fort Pierce, Florida, made a moving presentation based on her firsthand knowledge of the concerns of vulnerable populations, which she earned through years of service in the fields. She told the group that most of the men and women who

make up the seasonal farm worker population are uneducated and do not qualify for jobs other than the ones in which they are employed. "But there is evidence of education in our hearts, in our joints that are swollen and arthritic from repetitive movement and working in the cold, in our minds, and in our souls from our years of working in the fields," she told the group.

"I'm here today because I want to be among a group of people who can make a difference in meeting the health care needs of seasonal and migrant farm workers. I want to be among a group of people whose concern it is that this group is not left out."

The 4 million adults and children performing migrant farm work, many of whom are undocumented workers, are entitled to health care because they contribute valuable services to the economic welfare of the Nation. Their work fills the produce department of every grocery store in the Nation, every pantry, and every kitchen. Yet, these workers say they are frightened by the fact that they are being excluded from coverage in many health care reform proposals. Not only are these people fully entitled to health care, but they are greatly in need of it.

There is concern about the exclusion of seasonal and migrant workers in the original Washington State health care plan, a plan many states have viewed as a model for their own programs. There also is concern that health care reform will result in a mandate for employer-provided coverage. If this is the case, who is responsible for financing the health care of the migrant and seasonal farm worker? Will it be the farm owner or the crew company?

"Most of us, the men and women who make up the seasonal farm worker population, are uneducated and don't qualify for jobs other than the ones we have currently. But there is evidence of education in our hearts, in our joints that are swollen and arthritic from repetitive movement and working in the cold, in our minds, and in our souls from our years of working in the fields."

Many seasonal and migrant farm workers work for several farms or crew companies each year; they may even work for different employers within the same day. Should these workers be considered self-employed, even if they do not earn enough to provide health care coverage for themselves? If State-provided insurance is mandated and a migrant farm worker is rarely in one state for more than 4 months of a year, which state will provide coverage? Which state is responsible for a person's coverage when he or she is enroute to another job or between employers? These are some of the questions that require answers if health care reform is to improve care for migrant and seasonal farm workers.

The issue of immunization for undocumented children is another major concern for this population. Only one health care reform proposal has mentioned the allocation of funds to increase outreach efforts among health care providers for immunization services, but this proposal also excludes undocumented persons. There is further concern that some states are proposing legislation that would require health care facilities, providers, and public schools to report on any undocumented children attending a public school or seeking medical care.

Providing appropriate care for seasonal and migrant workers is essential because it can help reduce the overall cost of health care for the Nation. Likewise, denying care to this group also may have serious public health implications on the rest of the Nation. For example, an undocumented citrus picker who has been found to have active tuberculosis cannot seek care. If he does not return to work, he cannot support his family. When he returns to the labor camps, he will be housed in a room with five or six other single males who also may contract the tuberculosis. Thus, his disease can spread at an epidemic rate and possibly affect members outside of his group.

THE ROLE OF ESSENTIAL COMMUNITY PROVIDERS IN A REFORMED HEALTH CARE SYSTEM: A PANEL DISCUSSION

The first panel featured a discussion of the role of essential community providers in a reformed health care system. The following panelists represented many aspects of community health care provision:

Moderator: Grace Wang, M.D., Medical Director, Chinatown Health Clinic

Paula S. Gomez, Executive Director, Brownsville Community Health Center

Leonard E. Lawrence, M.D., President, National Medical Association

Irwin Redlener, M.D., F.A.A.P., President, The Children's Health Fund

Aaron Shirley, M.D., Project Director, Jackson-Hinds Comprehensive Health Center

Panel members conveyed that community-based providers and advocates have an important role in any reform of the health care system to serve vulnerable populations. The firsthand experience that these providers have in serving vulnerable populations offers valuable insight into what is needed in health care reform to meet their needs.

The continued role of community health centers and other essential community providers in a reformed health care system can be summarized as follows.

- Community-based providers bring to the health care delivery system an understanding of community needs and community priorities.
- Community-based providers serve as points of entry into a system of care that is culturally and linguistically competent and provides comprehensive primary care that is responsive to their specific needs.
- They provide the enabling services required to ensure access by vulnerable populations to health care, including outreach, transportation, translation, child care, and community health awareness.
- Traditional providers of care to vulnerable populations will be able to maintain relationships with existing providers and serve as a buffer between their patients and aggressive enrollment practices that may evolve in a managed care environment.

"Very often on my way to work, I'll see vans picking up groups of men in Chinatown to take them to work in restaurants in the suburbs. So those of you who live in the suburbs and always wondered who staffed your restaurants, that's where these people come from. These men usually are away from their families for 6 days a week, and the day that they have off varies from week to week, . . . so it's important that we have a 7-day-a-week service."

"Our inability to provide health care for homeless children in an effective, comprehensive way speaks poorly of us as a society, not so much because we have not figured out the tools to take care of homeless or other vulnerable populations—we have those tools—but it speaks poorly about us because we have that kind of population in the first place."

The situation of homeless and "housing-impaired" children also was addressed by the panel. Children who are "officially" designated as homeless represent only a fraction of the total number of "invisible" homeless children. These include children living in substandard housing. One major problem is the classification of families into programs that will allow them to receive benefits. Strapped for funding, many states do not designate some needy individuals as officially homeless because this would entitle them to special services and entitlements under public-sector programs.

"Many families live in abandoned shacks or apartment buildings without utilities and in fundamental squalor. These are often on private property, and when the owner of that property finds them, they simply move on. Because they have a roof over their heads, they are not technically homeless and are denied entitlement under many public-sector programs."

The lives of vulnerable populations are characterized by poverty, stress, and often the lack of a medical home. Psychosocial dysfunction often is present as a result of

these stressors. Therefore, it is imperative that any health care reform, whether it involves managed care or a fee-for-service system, incorporates certain program elements. For the homeless, this means that mental health benefits and case management services are vital. It also means that mobile medical units and computerized medical records must be provided as part of a system that can follow the homeless. Finally, there must be a referral system so that individuals can be provided with the advanced medical services before a health condition becomes serious.

The impact of managed care on vulnerable populations also was discussed by the panel. Essential community providers, who have been on the front line for years, now find themselves being squeezed out by major managed care systems who have found it profitable to care for this population. Squeezing out essential community providers will be a disservice to the provision of quality care.

MEETING THE NEEDS OF VULNERABLE POPULATIONS: THE HEALTH INSURANCE INDUSTRY RESPONDS

The following representatives from the Nations health insurance industry responded to the issues raised concerning vulnerable populations and health care reform:

Moderator: Jack Cradock, Chief Executive Officer, East Boston Neighborhood Health Center

Raymond J. Fabius, M.D., F.A.A.P., Medical Director, U.S. Healthcare

Karen Ignagni, President and Chief Executive Officer, Group Health Association of America

Anthony R. Masso, Senior Vice President, Health Insurance Association of America

The group outlined the objectives that they felt the two types of organizations share and discussed the challenges facing both groups. Panel members shared the belief that managed health care plan professionals are capable of working with community health providers and are eager to respond to the needs of vulnerable populations. They emphasized that community health centers and other community-based providers have made important contributions to the health care delivery system that should not be lost in health care reform. They outlined the following health care reform objectives that they felt both groups shared, which included the following:

- Universal coverage for all Americans.
- A well-defined set of comprehensive benefits for all Americans, with an emphasis on preventive and primary care.
- Integrating services and delivery systems that respond to the needs of vulnerable populations.
- Adequate reimbursement at the State and Federal levels.
- Established relationships with a primary care physician.
- Cost containment that eliminates government cost-shifting and provides adequate risk adjustment mechanisms, not premium caps and price controls.
- A single-tier health care system that eliminates the need for special programs for vulnerable patients.

"Representatives of managed care plans are enthusiastic about meeting to discuss ways of voluntarily working together with community providers and building on the strengths that each group has developed."

Panel members agreed that universal coverage itself will not provide adequate care to improve the health status of vulnerable populations. Private insurers, both from a fee-for-service and a managed care perspective, need to address the special concerns of vulnerable populations and acknowledged that they should do more to provide outreach programs and translation services.

Panel members also stressed that managed care could offer vulnerable populations wellness and screening programs, with a focus on the medical management for a high-risk patient population. To provide quality care, however, an examination of structure, process, and outcome

"Community health providers, the health insurance industry, and the Government must collaborate to create a system that meets the unique needs of vulnerable populations."

indicators is needed. In addition, a mutual data base that can compare clinical protocols and guidelines should be developed.

Panel members believe that in the future, community-based providers will have to choose to become managed care plans or work together with managed care insurers. Although representatives of managed care plans are opposed to Federal requirements that they contract with specific community providers, they are enthusiastic about meeting to discuss ways of voluntarily working together and building on the strengths that each group has developed.

In conclusion, panel members indicated they believed that community health providers, the health insurance industry, and the Government must collaborate to create a system that meets the unique needs of vulnerable populations.

A LEGAL PERSPECTIVE

King County, Washington, the county that includes the Seattle area, has recently implemented mandatory managed care for its Aid to Families with Dependent Children (AFDC) population. Janet Varon, J.D., Staff Attorney for Evergreen Legal Services, shared observations on the experiences of the individuals and families whose lives have been affected by the changes in health care delivery. The King County project can be viewed as a testing ground for health plans adjusting to the managed care approach.

The managed care plans that have succeeded in the King County program are tightly organized; have had previous experience working with vulnerable populations; have good communication with their providers; and have staff members who can assist clients in navigating through the maze of requirements, both inside and outside the plan. But many plans have encountered problems meeting the needs of vulnerable populations. One major problem with many managed care providers is that they are unaware of substance abuse services, transportation services, case management, and homeless health care resources in the community. A knowledge of these resources is essential in treating vulnerable populations.

Thus far, the King County project has demonstrated that protections such as financial penalties, requirements that plans notify members of their right to change plans, and similar protections must be included as Federal requirements in mandatory managed care programs. The presence of an ombudsman to provide quality control investigations would be helpful in identifying noncompliant plans. The absence of copayments in these types of systems is a positive aspect because they could seriously compromise access to care for the most vulnerable families, the homeless, and individuals with disabilities.

PLENARY DISCUSSION

As a wrapup to the first half of the Symposium, William D. Hobson, M.S., Executive Director of the Central Seattle Community Health Centers, moderated a question-and-answer session between participants and members of the community provider panel and the health insurance industry panel.

Participants voiced the concern that, although a single-tiered health care delivery system is a desirable long-term goal, several other components of reform are needed before this can be achieved, including guaranteed access to care, a guaranteed payment source, and support services. Both participants and panelists agreed that a shift must be made in the assumptions physicians make in treating patients (e.g., all patients have homes and can care for themselves). It also was noted that, although cost containment is a vital part of health care reform, the delivery system must first be centered around clients' needs.

Concerns were voiced that many managed care programs must include more nurses or nurse practitioners in their delivery of care. In addition, the involvement of minority physicians in the decisionmaking efforts of managed care plans also must be strengthened. Regulations that eliminate the insurers' ability to refuse coverage to uninsured individuals with high-cost conditions such as those in need of an organ transplant also must be included in reform.

"We can get into arguments over whose population is the most vulnerable. All of these groups are the most vulnerable if we consider the economic productivity that is limited when appropriate health care is not available."

Many community-based providers feel it is vital that managed care plans be required to contract with community-based providers. However, it has been observed that many managed care plans have been reluctant to provide services to some vulnerable populations. An insurance industry representative responded that managed care plan providers are interested in engaging in a dialogue to bridge the gaps that separate the two groups.

Insurance industry panel members were also asked to specify what initiatives the industry has taken to address the issue of violence. An industry representative responded that not nearly enough had been done in this area, and a shift is needed in how the issue is viewed. Society needs to see violence as an epidemiological concern and to make it a true priority in health care reform, for both vulnerable populations and the Nation as a whole.

"We must make a shift in thinking about how health care is delivered that consists of a thorough examination of the assumptions physicians make in treating patients such as the assumption that patients have homes and can care for themselves. Health care providers are trained to deliver treatment plans for people who have a home. If we don't ask the right questions, we won't provide the right treatment and end up with a 'noncompliant' client who may be held at fault but can in no way be accountable."

KEYNOTE INTRODUCTION: CIRO V. SUMAYA, M.D., M.P.H.T.M.

In introducing Surgeon General M. Joycelyn Elders, M.D., Ciro V. Sumaya, M.D., M.P.H.T.M., Administrator, HRSA, indicated that serving the health care needs of the vulnerable populations may be the greatest challenge the Nation faces today in the areas of public health and health delivery services. The solution to these problems relates not only to themes of decency, compassion, and social justice but also to epidemiology and the "nuts and bolts" of how health care is approached and delivered.

Vulnerable populations in the United States are growing and becoming increasingly more diverse. The homeless, who are traditionally stereotyped as being men with alcohol or substance abuse problems, now include women, children, and the elderly, all of whom may have different health care needs.

"The health of vulnerable populations is an issue that cuts across not only themes of decency, compassion, and social justice but also epidemiology and the 'nuts and bolts' of how health care is approached and delivered."

Dr. Sumaya told the audience that he hoped the Symposium would stimulate informed advocacy on behalf of the vulnerable members of society. Symposium participants have the tremendous responsibility of ensuring that the need for health care for vulnerable populations is recognized. Dr. Sumaya assured them that HRSA would work with them in their efforts.

In introducing Dr. Elders, Dr. Sumaya called her a pioneer at taking on responsibilities that have exceeded the traditional role of her position. While previously serving as Director of the Arkansas Department of Health, among many other achievements, Dr. Elders worked to increase the number of early childhood screenings in the state from 4,000 to 45,000 in 4 years and was successful in increasing the number of women who received regular prenatal care. Dr. Elders is turning her office into the most visible and vibrant platform for advocacy of healthy behaviors.

KEYNOTE SPEAKER: M. JOYCELYN ELDERS, M.D., SURGEON GENERAL

Dr. Elders told the audience that there are as many as 43 million Americans who could be considered vulnerable. Children are among the most vulnerable members of this group. More than 1 million Americans are homeless, and one-third of these individuals are children. In 1970, 1 in 7 children were poor. In 1990, this number was 1 in 5. From 3 to 5 million children go to bed hungry each night; another 8 to 12 million go to school hungry each morning. Only 44 percent of children under 2 years of age have all of their required immunizations.

The most significant aspect of our health care system is that rather than being a true "health care" system, it is an array of services offered by many different organizations and people to help those with health care problems. In fact, it is a "sick care" system. An overwhelming majority of the funds spent on health care in the United States go toward treating illnesses rather than preventing them. Less than 1 percent of the $940 billion spent annually on health care in the United States goes toward prevention. Preventive efforts such as immunization, prenatal care, and health education can contribute significantly to keeping people healthy. Thus, any system emerging from health care reform must make prevention a priority.

The following aspects must be emphasized if the delivery of health care to vulnerable populations is to become a reality:

- **Prevention.** Prevention programs can help to reduce morbidity and mortality among vulnerable populations.
- **Outreach and linkages to the community.** Every community has a school and a church, and these resources must be enlisted to keep the community healthy.

"A teenager asked the driver of a bus for the elderly if he would drive her to the clinic to get care for her sick baby. He told her the bus was only for the elderly, and he would lose his job if he took her. Three days later, she returned to the bus with the baby, who by that time had a stiff neck and his head was bent back. The driver said, 'I don't care if I lose my job lady, I'll take you.' When the child reached the clinic, a simple case of otitis media, which could have been treated with a $50 prescription, had progressed to a dangerous condition. From the clinic, the child was taken by helicopter to a children's hospital for 60 days of care and is now in a children's facility, receiving services that will probably cost more than $1 million."

- **A focus on education.** Vulnerable populations must be educated on how to become and stay healthy.
- **Comprehensive health education.** The involvement of schools in comprehensive health education programs from kindergarten through the 12th grade is necessary.
- **Enabling services such as day care, child care, and translation.** Providing these services involves establishing networks with community physicians, health departments, medical schools, community service organizations, and members of the community.

Dr. Elders also discussed the important role that essential community providers have played to many individuals and assured Symposium participants that they would be protected and strengthened by the President's health care reform proposal.

ASSURING ACCESS TO CARE UNDER STATE AND FEDERAL HEALTH CARE REFORM PLANS: A PANEL DISCUSSION

The afternoon session of the Symposium featured a group of State administrators and congressional legislative staff reporting their experiences under State health reform mandates and describing the pertinent provisions in the various health care reform bills in the U.S. Congress.

Moderator: Sara Rosenbaum, J.D., Senior Research Staff Scientist, Center for Health Policy Research, The George Washington University

Esther Aguilera, Legislative Assistant, Congressional Hispanic Caucus

Katherine Hayes, Legislative Assistant and Representative for Christine C. Ferguson, J.D., Office of Senator John Chafee

Ellen R. Shaffer, M.P.H., M.S.W., Legislative Assistant, Office of Senator Paul D. Wellstone

Christopher G. Atchison, M.P.A., Director, Iowa Department of Public Health

Kathryn Wood-Dobbins, M.S.S.W., Executive Director, Tennessee Primary Care Association

The major issues on which many states are focusing on in providing care to vulnerable populations can be divided into two main categories:

- **Assuring access to care.** This area involves entitlement benefits, comprehensiveness of benefits, essential provider designation, health alliance coverage, workforce priorities, enabling services programs, and school health programs.
- **Assuring quality and value in health care.** This area involves the establishment of uniform data sets, health information systems led at a national level, the National Quality Management Program's measures of performance, the evaluation of a quality management program, and finally, establishment of practice guidelines and parameters that will help states know what should be expected for the health care dollars spent.

Marketplace forces are the basis of most State health care reform proposals—an approach which traditionally has not met the needs of vulnerable populations. Because legislation authorizing State health care reform plans has been driven by the needs of the majority, Federal reform must avoid a situation in which people who fall outside the norm also fall outside of the health care system.

Federal panelists described the various bills being debated by committees of the U.S. Congress. There is a remarkable degree of similarity between the various pieces of legislation on vulnerable populations. All of the major bills discussed either provide direct funding or seek funding for development of new services as needed. Each bill, either through the benefit package itself or through the contracting requirements, recognizes the importance of essential community providers. The President's bill contains provisions to prevent discriminatory activities by health care plans that will help high-risk individuals. The Stark package also contains strong nondiscrimination provisions and provides direct coverage for federally qualified health centers. Access provisions in this bill broaden the definition of what is a qualified health center as well as contracting provisions for other essential providers.

"Issues of civil privacy protection must be addressed to ensure that a health identification card does not become a *de facto* national identification card to single out those who look and sound foreign. We cannot solve the Nation's immigration problems through the health care system."

Although some of the issues affecting vulnerable populations are being addressed by proposed legislation, these issues could disappear from the final legislation unless policymakers at all government levels are petitioned rigorously on the needs of this population and the importance to society of providing for them. It is imperative that representatives, senators, and State legislators know that these issues are just as important, if not more important, than employer mandates and price controls.

SEEKING SOLUTIONS: ADVOCACY ORGANIZATIONS RESPOND AND COMMENT

The Symposium's final panel summarized the day's major themes from the perspectives of advocates for vulnerable populations.

Moderator: Jeffrey Levi, Director of Public Policy, AIDS Action Foundation

Susan B. Drake, J.D., Senior Attorney, National Immigration Law Center, and Representative, National Council of La Raza

Barbara Eyman, Associate and representative for Larry S. Gage, National Association of Public Hospitals

Jacquelyn Gaines, M.S., C.R.N.P, past President, National Health Care for the Homeless Council

Dan Hawkins, Director, Division of Policy Research and Evaluations, National Association of Community Health Centers

Panel members noted that the community of advocates for persons with HIV and AIDS has done a phenomenal job in setting up a safety net for that population. Although these provisions may not be fully adequate, they have been developed and funded in a very short time and are serving the needs of many individuals. To build on this experience, the Panel expressed the importance of the need for advocates for vulnerable populations to be very specific in

articulating their needs to lawmakers and the Administration.

"The role of our Government is not just to respond to those who scream the loudest but to listen and respond equally for those who have no voice and cannot speak at all."

It is important that advocates for vulnerable populations not sound like they are protecting yet another special interest program, but rather are working to integrate society's most needy individuals into the health care system. The issue is not whether or not a program survives but that the vulnerable populations receive the services they need. It is also important for advocates to recognize that the system is changing rapidly, and although many of the current channels for delivering health care to the vulnerable are effective, they may be managed differently in the future.

The Nation's public hospitals, a major health care provider for vulnerable populations, also will be greatly affected by health care reform. The National Association of Public Hospitals (NAPH) represents approximately 100 inner-city hospitals that have been serving as family doctors for the poor and can be considered, along with a number of other community provider groups, as health insurance by default. The NAPH is concerned that the entire health care debate has not placed sufficient emphasis on the need for integrated and enabling services for the poor. They are also concerned about essential community provider status and the benefits of being an essential community provider as well as disproportionate share adjustments under Medicare and Medicaid.

The National Health Care for the Homeless Council (NHCHC) has obtained a great deal of knowledge on the impact of health care reform on homeless people. The NHCHC has found that enrollment barriers are a major obstacle to providing health care for the homeless. Homeless people rarely have access to documents that provide their identity, residence, or financial status. Thus, any health care system with rigid eligibility requirements for subsidies will exclude a significant number of homeless persons.

The Council recognized the importance of the organizations funded by the Health Care for the Homeless (HCH) Program. These organizations know how to reach homeless people and have developed the capacities to perform outreach, establish trusting relationships, and incorporate knowledge of clients' living situations into treatment plans.

Advocates for the homeless are challenged to ensure that patient care for this population is managed mutually by patients and providers and not mediated by insurance, insurers, or accountants. Care coordination must become an enabling function that promotes the use of appropriate services rather than act as a gatekeeping function that denies access to care in the service to the fiscal bottom line.

No current health care proposals address the issue of funding for mental health and addiction services. The neglect of these benefits in the current system has consigned tens of thousands of vulnerable citizens to sidewalks and alleys throughout the Nation. Public funding for such services has been criminally inadequate at all levels of government. Thus, advocacy organizations are challenged on many levels to build the popular movement for a right to health care in its entirety.

A major underpinning of the work of the NHCHC is that health must be broadly and positively defined so that efforts will have a sufficient impact on the vulnerable. Defining health as only the absence of disease is insufficient in relation to the many and varied aspects of the lives of the homeless. For example, homeless persons with medical treatment needs urgently require housing as a fundamental basis of care. Thus, a reformed health care system must offer an ecological approach that takes into consideration the environment within which the vulnerable live—their housing, nutrition, income,

"If you are homeless for more than 2 weeks, your personal possessions are gone. In terms of enrollment for health care benefits, this means you don't have your birth certificate in your back pocket or a briefcase that contains documents providing your identity, residence, or financial status. Thus, any health care system with rigid eligibility requirements will exclude a significant number of homeless persons."

family connections, and other related factors.

In addition to the concerns of the homeless, the Panel further addressed the health care status of the Nation's immigrant and undocumented population. Of the Nation's 19 million foreign-born individuals, approximately 16 million have legal status, either as refugees or legal permanent residents. These individuals work and pay taxes. The media has given much attention to the concern that providing health care coverage to undocumented immigrants will have a magnet effect, drawing many more immigrants to the United States. However, the experience of the State of Arizona shows that this is not true. In the mid-1980's, the state developed a managed care system that provided primary, preventive, and emergency care for every state resident, regardless of immigration status. This program had no appreciable impact on undocumented immigration into the state. Further studies show that undocumented immigrants come here for jobs, to reunite their families, and to flee political persecution, just as legal immigrants do. The overwhelming majority of these immigrants do not receive welfare benefits.

"If some of us win and others don't, then we all lose. This is not only about community, migrant, and homeless health centers or public hospitals. It's not just about the undocumented, or homeless, or migrant farm workers. It's about all of us. None of us will pull out of this alone. The only way we have a fighting chance is by working together."

For health care reform to address the needs of the Nation's undocumented population, all individuals who work must receive care. It is critical that people be able to enroll their spouses and children in their health care plans. This will ensure that individuals in families of mixed immigration status have access to the system when someone in the family is eligible. Provisions for states to be able to pick up coverage also are useful. Emergency care is now provided for individuals who are eligible for Medicaid, regardless of immigration status. Funding for those ineligible for Medicaid must be preserved and strengthened. Prenatal care is an especially cost-effective and necessary service that should be provided for all.

An additional major concern is how reform will effect the programs of the BPHC. If the middle class believe that health care reform is a solution to the problems of providing health care to vulnerable populations, the ability to obtain congressional support for these programs will be lost. With current funding, the BPHC is only able to serve 15 percent of those eligible for services out of the approximately 37 million uninsured individuals. It will be increasingly difficult to maintain existing programs, let alone expand them, if there is widespread perception that this problem has been solved.

It is important that advocates for these populations strive to integrate society's most vulnerable individuals into the health care system rather than work to protect specific programs. It is also important for advocates to focus on the positive aspects of the various proposals rather than only criticize them. Advocates should avoid splintering into statements of "must-have's" for their individual programs and start building consensus among the various proposals now being debated. Furthermore, they must not appear resistant to change. The system is changing rapidly, and although many of the current channels for delivering health care to special populations are effective, they will be managed differently in the future.

The Panel ended with a call to advocates for vulnerable populations as well as the providers and administrators serving them to make health care for vulnerable populations a reality. This means calling their members of Congress and members of the Congressional Ways and Means, Energy, Commerce, Education, and Labor Committees as well as others involved in health care reform to tell them that America cannot allow the health care system to discriminate against vulnerable individuals, their communities, and those who care for them. It is necessary to fight for assured funding for community health, access to services, research, and substance abuse and mental health programs as well as for a broad definition of essential community providers.

"America cannot allow the health care system to discriminate against vulnerable individuals, their communities, and those who care for them."

Closing Wrapup: A Reflection of Key Issues

Why do I go on? I'm a dreamer, an incredible dreamer, with a tiny spark hidden somewhere inside me, which cannot die, which even I cannot kill or quench, and which tortures me horribly because all the odds are against its continued burning. In the midst of the decay and savagery, this spark speaks to me of beauty, of human worth and kindness, or goodness, or greatness, or heroism and martyrdom, and it speaks to me of love."

– Symposium closing remarks (as quoted from Eldridge Cleaver) presented by:
Reed Tuckson, M.D.
President
Charles Drew University of Medicine and Science

Reed Tuckson, M.D., provided a moving set of closing remarks for the Symposium. Dr. Tuckson, President, Charles Drew University of Medicine and Science, has previously served as the Senior Vice President for Programs for the March of Dimes Birth Defects Foundation and Commissioner of Public Health for the District of Columbia. He is an active member of the Institute of Medicine of the National Academy of Sciences and serves on many boards and committees such as the Foundation for Health Services Research, the American Public Health Association, Physicians for Social Responsibility, and the Black Community Crusade for Children.

Dr. Tuckson told the group that most Americans' main concern regarding health care reform is middle-class liability for escalating insurance costs rather than providing care to the 37 million uninsured in the Nation. Because economic concerns are central to this debate, a powerful key argument of those serving the health care needs of vulnerable populations is that, through their experience and expertise, they have earned a functional and competitive business advantage for serving these individuals. In their operations, providers must strive to improve this advantage in every way possible to ensure their preeminence in providing quality services.

The unique and overwhelming advantage community providers have over any provider unfamiliar with vulnerable populations can be demonstrated in the following example. Dr. Tuckson cited a case in which a woman, who may have been physically abused but showed no outward signs of abuse, visited a health care provider several times with the same complaint before her condition was diagnosed. The woman was reticent and offered very little information to the provider. A physician unknowledgeable about the clinical epidemiology of vulnerable populations may require extensive and diagnostic testing to diagnose this woman. However, a physician who is aware that women are often abused by men who do it without leaving marks may know to check her tympanic membrane to see if it is broken. Thus, the doctor will make a faster and more cost-effective diagnosis. Knowledgeable providers also are best at communicating the therapeutic regimen to patients in the most appropriate way. However, they must be able to prove this to decisionmakers and the community at large if they are to win their support.

It is also important to emphasize that all Americans can be affected by diseases such as tuberculosis, which may begin in vulnerable communities. To improve the care delivered to vulnerable populations, it is essential that public health departments, community health centers, and medical academic centers in the community work together.

"Because economic concerns are central to health care reform, a powerful key argument of those serving the health care needs of vulnerable populations is that, through their experience and expertise, they have earned a functional and competitive business advantage for serving vulnerable populations."

The development of partnerships also is important to ensure that the health care needs of vulnerable populations are met. The Congressional Black Caucus is a very important group to work with in this process. Also, within the African-American community, the National Medical Association has united with organizations representing black nurses, pharmacists, dentists, HMO's, and veterinarians to fight for health care reform. Advocates also should establish linkages with the largest organizations of black business professionals to find the *pro bono* services necessary to turn neighborhood health centers into economically "lean and mean" players. Innovative ideas are also needed for marketing programs for centers to keep their patient base with them and not lose patients through Medicare to the private sector. Without the practical means to ensure that the needs of the vulnerable are met, health care reform will change nothing for vulnerable populations.

"Pity and compassion in a world of pain mean nothing at all unless they lead to change."

Symposium on Health Care Reform: Assuring Access for Vulnerable Populations

March 23, 1994

Agenda

8:30 a.m. - 8:45 a.m.

Welcome

Marilyn H. Gaston, M.D.
Assistant Surgeon General
Public Health Service
Director
Bureau of Primary Health Care

Robert O. Valdez, Ph.D.
Deputy Assistant Secretary for Interagency Policy
Health Care Financing Administration
Public Health Service

Tom Van Coverden
Executive Director
National Association of Community Health Centers

Introductions

Joan Holloway
Director
Division of Programs for Special Populations
Bureau of Primary Health Care

8:45 a.m. - 9:15 a.m.

Policy Paper: Vulnerable Populations and Health Care Reform

Ann Zuvekas, D.P.A.
Senior Research Staff Scientist
Center for Health Policy Research
The George Washington University

9:15 a.m. - 9:30 a.m.

A Consumer's Perspective

Hazel Filoxsian
Seasonal Farmworker and Director
Migrant and Immigrant Assistance Center

9:30 a.m. - 10:30 a.m.

The Role of Essential Community Providers in a Reformed Health Care System

Moderator: Grace Wang, M.D.
Medical Director
Chinatown Health Clinic

Panelists:

Paula S. Gomez
Executive Director
Brownsville Community Health Center

Leonard E. Lawrence, M.D.
President
National Medical Association

Irwin Redlener, M.D., F.A.A.P.
President
The Children's Health Fund

Aaron Shirley, M.D.
Project Director
Jackson-Hinds Comprehensive Health Center

10:30 a.m. - 10:45 a.m. **Break**

10:45 a.m. - 11:15 a.m. **Meeting the Needs of Vulnerable Populations: The Health Insurance Industry Responds**

Moderator:

Jack Cradock
Chief Executive Officer
East Boston Neighborhood Health Center

Panelists:

Raymond J. Fabius, M.D., F.A.A.P.
Medical Director
U.S. Healthcare

Karen Ignagni
President and Chief Executive Officer
Group Health Association of America

Anthony R. Masso
Senior Vice President
Health Insurance Association of America

11:15 a.m. - 11:30 a.m. **A Legal Perspective**

Janet Varon, J.D.
Staff Attorney
Evergreen Legal Services

11:30 a.m. - 12:15 p.m. **A Discussion With the Audience**

Moderator:

William D. Hobson, M.S.
Executive Director
Central Seattle Community Health Centers

12:15 p.m. - 1:30 p.m. **Lunch**

1:30 p.m. - 1:45 p.m. **Keynote Introduction**

Ciro V. Sumaya, M.D., M.P.H.T.M.
Administrator
Health Resources and Services Administration

Keynote Speaker:

M. Joycelyn Elders, M.D.
Surgeon General
Public Health Service

1:45 p.m. - 3:15 p.m. **Assuring Access to Care Under State and Federal Health Care Reform Plans**

Moderator:
Sara Rosenbaum, J.D.
Senior Research Staff Scientist
Center for Health Policy Research
The George Washington University

Federal Panelists:
Esther Aguilera
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Katherine Hayes
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Ellen R. Shaffer, M.P.H., M.S.W.
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State Panelists:
Christopher G. Atchison, M.P.A.
Director
Iowa Department of Public Health

Kathryn Wood-Dobbins, M.S.S.W.
Executive Director
Tennessee Primary Care Association

3:15 p.m. - 4:15 p.m. **Seeking Solutions: Advocacy Organizations Respond and Comment**

Moderator:
Jeffrey Levi
Director of Public Policy
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Panelists:
Susan B. Drake, J.D.
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Barbara Eyman
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Jacquelyn Gaines, M.S., C.R.N.P.
Past President
National Health Care for the Homeless Council

Dan Hawkins
Director
Division of Policy Research and Evaluations
National Association of Community Health Centers

4:15 p.m. - 4:45 p.m. **A Discussion With the Audience**

Moderator:
William D. Hobson, M.S.
Executive Director
Central Seattle Community Health Centers

4:45 p.m. - 5:15 p.m.

Closing Wrapup: A Reflection of Key Issues

Reed Tuckson, M.D.
President
Charles Drew University of Medicine and Science

Symposium on Health Care Reform: Assuring Access for Vulnerable Populations

March 23, 1994

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